

CHAMPVA POLICY MANUAL

CHAPTER 3
SECTION 6.3
TITLE: COST-TO-CHARGE (CTC) PAYMENT SYSTEM

AUTHORITY: 38 CFR 17.270(a), 17.272(b) and 17.274

RELATED AUTHORITY: 32 CFR 199.14(a)(1)

I. EFFECTIVE DATE

October 8, 1987

II. DESCRIPTION

The cost-to-charge payment system is used to determine the allowable cost for inpatient care furnished by a hospital or a facility not covered by the DRG-based prospective payment system or the inpatient mental health per diem payment system. This payment system is also applicable to hospital stays that are exempt from the DRG-based payment system based on diagnosis. The current cost-to-charge rate is 100 percent of the billed charge.

III. POLICY

A. Health Facilities Covered by Cost-To-Charge (CTC). The following hospitals are considered exempt, or excluded from the DRG-based payment system and per diem payment system. These hospitals are subject to the CTC (billed charge) payment methodology:

1. Cancer hospitals. Any hospital that qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare Prospective Payment System (PPS) is exempt from the DRG-based payment system.
2. Christian Science sanatoriums.
3. Foreign hospitals. Any hospital outside the 50 states, the District of Columbia, or Puerto Rico.
4. Long-term hospitals.
5. Non-Medicare participating hospitals.

6. Non-VA Federal Health Care Facilities (military treatment facilities, Indian Health Service).

7. Rehabilitation hospitals.

Note: Within this policy, rehabilitation hospitals do not include substance use disorder rehabilitation facilities (SUDRF) or psychiatric and substance use disorder rehabilitation partial hospitalization. [32 CFR 199.14]

8. Skilled Nursing Facilities (SNFs).

9. Sole community hospitals. Any hospital that has qualified for special treatment under the Medicare PPS as a sole community hospital and has not given up that classification is exempt from the DRG-based payment system.

10. State waivers. Any state that has implemented a separate DRG-based payment system or similar payment system in order to control costs for inpatient care may be exempt from the CHAMPVA DRG-based payment system. The only state currently exempt is Maryland. Inpatient services provided in the state of Maryland are paid at the rates established by the Maryland Health Services Cost Review Commission (HSCRC). Since Maryland hospitals are required to bill these rates, CHAMPVA reimbursement for inpatient services are to be based on the billed charge. Reimbursement for all outpatient and professional provider services will be based on the CHAMPVA maximum allowable charge (CMAC) (see [Chapter 3, Section 5.1, Outpatient and Inpatient Professional Provider Reimbursement](#)).

B. Services Covered by Cost-To-Charge. The following hospital services, even when provided in a hospital subject to the DRG-based payment system, are considered exempt and are subject to cost-to-charge.

1. All services related to solid organ acquisition, i.e., kidney, heart, lung, including donor inpatient stay, is paid on a reasonable cost basis and is not included in the DRG.

2. All services related to pancreas transplant alone (PTA), simultaneous pancreas-kidney (SPK) and pancreas after kidney (PAK) through September 30, 1999. Effective October 1, 1999, PTA, SPK, and PAK will be paid under the appropriate DRG. Acquisition costs will continue to be paid on a reasonable cost basis and are not included in the DRG.

3. All services related to heart, heart-lung, and liver transplantation through September 30, 1998. Effective October 1, 1998, heart and heart-lung transplants are paid under DRG 103 and liver transplants are paid under DRG 480. Acquisition costs related to these transplants will continue to be paid on a reasonable cost basis and are not included in the DRG.

4. All services related to lung transplantation through September 30, 1994. Effective October 1, 1994, lung transplants are paid under DRG 495. Acquisition costs related to the lung will continue to be paid on a reasonable cost basis and are not included in the DRG.

5. All services related to small intestine, combined small intestine/liver and multivisceral transplants through September 30, 2001. Effective October 1, 2001, these transplants shall be paid under the appropriate DRG. Acquisition costs related to these transplants shall continue to be paid on a reasonable cost basis and are not included in the DRG.

7. All services related to combined liver-kidney (CLKT) and combined heart-kidney transplant (CHKT) through July 31, 2003. Effective August 1, 2003, CLKT and CHKT will be paid under the assigned DRG based on the patient's diagnosis.

8. All services related to discharges involving pediatric bone marrow transplantation for patients under 18 years of age on the date of admission. (ICD-9-CM diagnosis codes V42.4 and ICD-9 procedure codes 41.00 - 41.09 and 41.91.)

9. All services related to discharges involving HIV seropositive admissions for patients under 18 years of age on the date of admission. (ICD-9-CM diagnosis codes 042, 079.53, and 795.71.)

10. All services related to discharges involving pediatric cystic fibrosis admissions for patients under 18 years of age on the date of admission. (ICD-9-CM diagnosis codes 277.0, 277.00, 277.01, 277.02, 277.03, and 277.09.)

11. All outpatient hospital services related to inpatient stays.

12. Blood clotting factor for hemophilia inpatients. **Payments rates for each unit of blood clotting factors have been established as indicated below:**

a. **For admissions occurring on or after October 1, 1997, through December 31, 2003, the following HCPCS codes and payment rates shall be used for blood clotting factors:**

J7193 Factor IX (antihemophilic factor, purified – non-recombinant,
\$1.05

J7195 Factor IX (antihemophilic factor – recombinant) \$1.12 per
unit

J7199 Hemophilia Clotting Factor, not otherwise classified (the
provider must report the name of the drug and how the drug is dispensed in the remarks
section of the claim)

Q0187 Factor VIIa (coagulation factor – recombinant) one billing
unit per 1.2 mg \$1,596 per unit

Q2022 Von Willebrand Factor (complex-human) \$0.95 per unit

b. Effective January 1, 2004, blood clotting factors are paid at the CHAMPVA maximum allowable amount (CMAC). The CHAMPVA CMAC rates are the same payment rates utilized by TRICARE. The CMAC rates are updated annually.

IV. POLICY CONSIDERATIONS

A. Under the cost-to-charge payment system calculation, the beneficiary inpatient cost share is 25 percent of the allowable amount (billed amount less any noncovered service or item). For covered services, beneficiaries are not responsible for amounts that exceed the CHAMPVA allowable.

B. Beneficiary Eligibility.

1. If the beneficiary is a patient in a non-DRG medical facility, the allowable costs through the day on which the beneficiary loses eligibility will be paid.

2. If the beneficiary gains eligibility while hospitalized in a non-DRG medical facility, the medical costs beginning with the day eligibility is effective will be paid.

C. Beneficiary submitted claims. All inpatient claims will be paid to the provider regardless of whether the beneficiary specifically requests payment.

D. Leave of Absence Days. In billing for inpatient stays, which include leave of absence, medical facilities are to use the actual admission and discharge dates and are to identify all leave of absence days. Leave of absence days are disallowed and neither CHAMPVA nor the beneficiary may be billed for days of leave.

E. Other Health Insurance (OHI). The OHI criterion applies to the cost-to-charge payment system. CHAMPVA is always the secondary payer of benefits when there is OHI except when the beneficiary has entitlement to Medicaid, State Victims of Crime Compensation programs, and CHAMPVA supplemental insurance. Payment of benefits may not be extended until all other double coverage plans or other health insurance has adjudicated the claim.

END OF POLICY